Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic and Spine Hospital at Arlington

Respondent Name
Pacific Indemnity Co

MFDR Tracking Number
M4-14-3287-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claim was denied due to no authorization of file; however our facility did in fact attempt to obtain an authorization via fax on August 29th, 2013 evidence in the supporting documents are provided."

Amount in Dispute: $10,496.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgment of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28 – 31, 2013	Inpatient Hospital Surgical Services	$10,496.50	$10,496.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment adjusted for absence of precert/preauth

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?

3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 9, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the disputed service as, 197 – "Payment adjusted for absence of precert/preauth." 28 Texas Administrative Code §134.600 (c) states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);" Review of the submitted medical records finds;
    a. Arlington Orthopedic Associates PA History and Physical, "the patient presents with fever in the office of 100.3. She states it was 104 last night, overall she looks tired and in pain. She complains of left leg pain and low back pain that has been getting worse. The patient has been experiencing left lower extremity and groin pain since Thursday. At this point, I have set her to BOSHA for a direct admit and given an order to several labs to be drawn (CBC with diff, BMP, ESR, CRP, blood cultures x2, UA) and a MRI of the lumbar spine with and without contrast."

    b. Baylor Orthopedic and Spine Hospital at Arlington Discharge Summary, "The patient was admitted to Baylor Orthopedic and Spine Hospital on August 28, 2013, due to a recurrent postoperative infection. Labs along with a new MRI were obtained, which suggested a recurrent postoperative infection."

    Based on the above the Division finds that the admission was as a result of an emergency situation and therefore the carrier is liable for the reasonable and necessary medical costs relating to the health care as defined in Rule 134.600(c). Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
    (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
    (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

    No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under 28 Texas Administrative Code §134.404(f).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
    (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
        (A) 143 percent; unless
        (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

    No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to 28 Texas Administrative Code §134.404(f)(1)(A).

5. 28 Texas Administrative Code §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be

found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 858, and that the services were provided at Baylor Orthopedic and Spine Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $10,365.0. This amount multiplied by 143% results in a MAR of $14,821.96.

6. The division concludes that the total allowable reimbursement for the services in dispute is $14,821.96. The respondent issued payment in the amount of $0.00. The requestor is seeking $10,496.50. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10,496.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.